Further Additional Materials for the Record

On July 17, 2003, the Subcommittee on Health held a hearing on the Health Insurance Certificate Act of 2003 and Mr. Robert Greenstein, Executive Director of the Center on Budget and Policy Priorities testified as one of the five witnesses. The official committee print of the hearing record failed to include Mr. Greenstein's responses to follow-up questions posed by the Subcommittee. The following is Mr. Greenstein's response that was not included in the official hearing print.

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The Honorable Michael Bilirakis
Chairman
Subcommittee on Health
House Committee on Energy and Commerce
2125 Rayburn House Office Building
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Dear Chairman Bilirakis:

Thank you again for the opportunity to present testimony at the Health Subcommittee hearing held on July 17, 2003 on the Health Insurance Act of 2003 (H.R. 2698). Please find below my written response to follow-up questions you submitted to me on August 4. I also include a response to the question you asked at the hearing of all of the witnesses about our recommended coverage option(s). I hope that these answers are helpful to you in your efforts to cover more uninsured Americans.

1. Do you argue that a Health Insurance Certificate Program for low-income families may inspire some employers to drop coverage but an expansion of Medicaid would not?

As I noted in my testimony (and as discussed in greater detail in my response to question #5), employers are unlikely to drop coverage under H.R. 2698 because of the restrictive income and asset limits on eligibility. If those limits are raised, however, substantial employer dropping would result. Similarly, a Medicaid and SCHIP expansion to parents is unlikely to lead to employer dropping due to the low-income of expected participants who are less likely to have access to employer-based coverage (as previous analyses of Medicaid expansions to parents have found). It is true that as with a health certificate approach, the higher up the income ladder a Medicaid expansion goes, the greater the possibility of employer dropping. Yet, the income eligibility level for Medicaid in the median state for parents is currently only 71 percent of the poverty line and only 16 states cover parents with family incomes up to 100 percent of the poverty line. (As a comparison, 39 states including the District of Columbia cover children up to 200 percent of the poverty line). Moreover, according to the Kaiser Commission on Medicaid and the Uninsured, a narrowly targeted expansion of this type (such as one only for parents only rather than for all workers) would make dropping by employers even at somewhat higher income eligibility levels less likely.

There is a key difference, however, between public program expansions and the health certificate approach with regard to the risk of adverse selection and its effect on the employer-based health insurance system. If the income and asset limits are raised, the health certificate approach would pose a substantial risk of adverse selection, while a Medicaid expansion at higher income levels would not.

Public programs like Medicaid and SCHIP offer affordable and comprehensive health insurance coverage. In addition, Medicaid and SCHIP are open to any eligible individual irrespective of age or medical history. As a result, the phenomenon of adverse selection that could result with the availability of a subsidy or tax credit for the individual market is not a risk with a public program expansion. Young and healthy workers would not necessarily find the public programs more attractive than employer-based coverage. In fact, because Medicaid provides services that meet the special health care needs of people with disabilities or chronic illnesses, the public program may be more attractive for sicker workers.

On the other hand, the individual market is more attractive to young and healthy individuals and less attractive to older and sicker people because the individual market may vary premiums by age or health status (and may exclude people entirely), and generally provides far less comprehensive coverage than is available through employer-based coverage. If older and sicker workers remain behind in employer-based coverage, then premiums for such coverage could rise. This phenomenon — known as "adverse selection" — could then induce yet additional younger, healthier workers to abandon employer-based coverage and use their subsidies in the individual market instead, since the departure of the first wave of younger, healthier employees would have caused premiums for employer-based coverage to rise. In this way, a vicious cycle could be set in motion. The increase in premiums for employer-based coverage that ultimately could occur could induce some employers either to cease offering health insurance or to increase substantially the amounts their employees must pay for insurance. The end result could be that a substantial number of older and less healthy individuals could eventually lose their employer-based coverage and become uninsured or underinsured or have to pay very large amounts for decent coverage.

The movement of substantial numbers of workers from employer-based coverage to the individual market is not likely under H.R. 2698 because of its restrictive income and asset eligibility requirements. Relatively few workers in these income ranges have access to employer-based coverage. If those income and asset eligibility limits were raised substantially, however, the health certificate approach would pose a substantial risk of adverse selection. This adverse selection risk does not exist in a public program expansion.

2. What evidence do you have that expanding SCHIP and Medicaid will have a lower price per person covered as opposed to a Health Insurance Certificate Program? What is that price per person under this proposal?

According to Professor Jonathan Gruber of M.I.T. who conducted an informal analysis of H.R. 2698, the estimated federal cost per newly insured person under the health certificate proposal would be $3,300. An estimate conducted by the Kaiser Commission on Medicaid and the Uninsured in 2002 found that an optional FamilyCare expansion of Medicaid and SCHIP to parents of children enrolled in those programs up to 200 percent of the federal poverty line would have a total government cost per newly insured person of $2,800, including both federal and state costs. (I note, however, that these numbers are not directly comparable because the Kaiser estimate was calculated using 2001 dollars, while the analysis of H.R. 2698 by Professor

Gruber uses 2003 dollars). The "price" per newly insured person is nonetheless relatively similar.

A further analysis beyond a "price" comparison, however, is necessary to evaluate appropriately the cost-effectiveness of these approaches. As cited in my testimony, Professor Gruber found that nearly 90 percent of estimated participants in the health certificate program were previously insured. As a result, the vast majority of the spending per newly insured person under H.R. 2698 would go not to the purchase of affordable and comprehensive health insurance for a currently uninsured individual but rather to modestly subsidize individuals who already have health insurance. Some of this spending actually goes to employers already offering health insurance coverage, to the extent that employers reduce their existing premium contributions by an amount equal to the value of the subsidy under the health certificate.

A countervailing factor, however, is that Professor Gruber estimates that 70 percent of participants would use the health certificates for employer-based coverage, where individuals are eligible only for partial subsidies equal to no more than 40 percent of the value of the full health certificate. This brings down substantially the cost per newly insured individual. Also, for health certificates used in the individual market, Professor Gruber assumes that individuals would only purchase health insurance plans in the individual market that are less comprehensive than they would obtain through employer-based coverage. He assumes that healthier and younger individuals who are low-risk would most be able to access the individual market. These factors, as well, would make the cost of coverage provided per newly insured person less expensive than it otherwise would be.

Under a FamilyCare expansion, most of the total government cost of $2,800 spent per newly insured person (both federal costs and state matching costs) would go to the comprehensive coverage provided to that individual. The Kaiser Commission assumes that 26 percent of projected participants would have previously had health insurance under such an expansion. The primary reason the total cost (including the state share) per newly insured person is somewhat comparable to that under H.R. 2698 is the quality and affordability of the coverage provided. Both Medicaid and SCHIP have premium and cost-sharing limits and provide a comprehensive set of health insurance benefits. These benefits are especially needed by those individuals with special health care needs; projected participants in a public program expansion are generally expected to be of poorer health and more expensive to insure. As a result, the cost of such coverage is greater than the cost of the less comprehensive coverage available in the individual market that would be provided under H.R. 2698 to what would be, in large, part, a lower cost (healthier, younger) population.

3. My understanding is that Medicaid is basically like a cliff. You either qualify or you do not. This creates an incentive for individuals not to earn over a certain amount for fear of losing Medicaid coverage. H.R. 2698 does not have this problem. First, it provides a softer landing for those who now make more than what Medicaid allows for. In this case, they could have significant help with employee premiums or on the individual market. In addition, the proposal has a phase down policy. What means are there to address the issue under a Medicaid-based proposal?

The Medicaid program provides a "softer landing" for certain beneficiaries under the Transitional Medical Assistance (TMA) program. Under TMA, families enrolled in Medicaid who become ineligible due to increased earnings can qualify for up to 12 months of temporary Medicaid coverage. (Families are eligible for only six months if their income exceeds 185 percent of the poverty line.) This can provide an essential work support "bridge" for low-income working families, especially for those leaving welfare for work. Unfortunately, the TMA program expires on September 30, 2003. (Your Committee did extend TMA for one year as part of the House-passed welfare reauthorization bill).

To strengthen the incentive for work, the TMA program should be made permanent or extended for the same period of time as the TANF program is reauthorized. To ensure that more eligible families receive TMA, states could be given additional simplification options to make it easier for families to participate. For example, states could be given the option to make less restrictive (or waive) onerous income reporting required for families participating in TMA under federal law. Often times, families eligible for TMA are disqualified for failure to make these timely and burdensome income reports to states. States have requested such simplifications for a number of years.

In addition, as I recommended in our testimony, Congress could expand Medicaid and SCHIP to parents of children enrolled in those programs. Currently, the income eligibility level in the median state for parents is 71 percent of the poverty line. Only 16 states cover parents with family incomes up to 100 percent of the poverty line. (As a comparison, 39 states including the District of Columbia cover children up to 200 percent of the poverty line). That would ensure that more low-income families that increase their earnings would retain access to health insurance coverage. Moreover, research has found that extending health insurance to low-income parents under the same public program so that the entire family can be covered under a single joint policy boosts enrollment of children and use of necessary services by children. In states that have expanded publicly funded coverage to include working parents, enrollment rates among children are significantly higher.

To avoid an eligibility cliff that discourages work, states that expand coverage for parents up to a certain minimum income level (say 185 percent or 200 percent of the poverty line) could be given additional flexibility to charge higher premiums to individuals with incomes above that level. There is already some existing state flexibility in this regard that could potentially serve as a model. For example, under Medicaid, at state option, people with disabilities returning to work who no longer qualify for Medicaid can "buy-into" Medicaid by paying premiums that can be set on a sliding scale based on income.

4. You cite an MIT study in your testimony. I assume you are not saying that 90% of the target population that is addressed by H.R. 2698 already has insurance? H.R. 2698 has certain income and asset ranges and is not available to those who have coverage under other public programs. Do you know what the percentage is in that population group that already has insurance? My understanding from the May 2003 Congressional Budget Office report, "How Many People Lack Health Insurance," is among families under 200%

of poverty level, 47% are uninsured at some point during the year and 19.5% are uninsured all year.

In my testimony, I referred to an analysis of H.R. 2698 conducted by Professor Jonathan Gruber of M.I.T. The 90 percent figure I cited is Professor Gruber's estimate of the percentage of projected health certificate participants who already have health insurance coverage. (It does not refer to the estimated percentage of the health certificate's target population who are insured.) Professor Gruber found that nearly 90 percent of projected health certificate participants would have previously had health insurance. In other words, only about 10 percent of individuals (and/or their families) using a health certificate would have been previously uninsured and subsequently gained insurance through the health certificate program.

According to an analysis the Center conducted on 2001 census data, about 34 percent of individuals in families of four with incomes below $25,000 (136 percent of the federal poverty line) are uninsured. (This is a point in time estimate.) We used $25,000 because it is the upper income limit for availability of the full health certificate credit amount of $2,750 for a family of four under H.R. 2698.

5. I understand that you have reviewed the President's proposal. H.R. 2698 makes a number of modifications to that basic set of ideas. Can you comment on the changes we have made in H.R. 2698 relative to the President's proposal and whether you think these are the right changes?

As my testimony indicates, I believe that H.R. 2698 has some serious shortcomings. The proposal is unlikely to help reduce the ranks of the uninsured by an amount commensurate with the expenditure of $50 billion. Chief among these concerns is that H.R. 2698 is not likely to be a cost-effective and well-targeted approach to covering the insured, with nearly 90 percent of participants projected to already have had health insurance.

However, I believe that H.R. 2698 includes differences from the health insurance tax credit proposal included in the Administration's fiscal year 2004 budget that would reduce the risk posed to the employer-based health insurance system. H.R. 2698 limits upper income eligibility for partial subsidies to $34,000 for a family of four (the full subsidy is available for families with incomes below $25,000) and also imposes an asset test of $20,000 for families. It also allows a partial subsidy for the employee to purchase employer-based health insurance system.

As a comparison, the Administration's tax credit limits income eligibility for partial subsidies to $60,000 for a family of four (the full subsidy is available for families with incomes below $25,000) and does not impose an asset test. It does not allow the tax credit to be used for employer-based coverage; it is to be used primarily in the individual market.

As I noted in my testimony, analysts from M.I.T., the Kaiser Family Foundation, and the Urban Institute have found that enactment of a broader subsidy for the purchase of health insurance (done through the tax code as a refundable credit) would encourage some firms not to

offer health insurance coverage to their employees because the firms would know their workers could now get a subsidy to purchase coverage in the individual market. According to an estimate Professor Gruber conducted of the Administration's tax credit from last year, the Administration proposal would cause employers to drop health insurance coverage for 2.4 million workers, of which 1.4 million (58 percent) would become uninsured.

This is not likely to be the case under the health certificate program: the restrictive income and asset limits would mitigate that risk. Professor Gruber expects little or no employer dropping under H.R. 2698. Similarly, in examining tax credits, the Urban-Brookings Tax Policy Center has found that if eligibility for such credits is limited to families with low-incomes, fewer employers will drop coverage, since the credits would be unavailable to many of their workers. The availability of partial subsidies for employer-based coverage also should somewhat reduce the likelihood that firms would drop coverage.

Moreover, under the Administration's tax credit proposal, some young, healthy low-income workers whose employers do offer coverage but require their employees to pay a substantial share of the premium would be able to opt out of employer-based coverage and instead use their tax credits to purchase insurance in the individual market. Professor Gruber estimated that the availability of the Administration's tax credit would cause 1.5 million workers to voluntarily leave the employer-based system and enter the individual market. If these young and healthy workers opt out of employer coverage, the pool of workers remaining in employer plans would become older and sicker, on average. That would drive up the average premium costs for employer-based insurance and further raise the amounts that the employees remaining in these plans must pay for insurance.

The movement of substantial numbers of workers from employer-based coverage to the individual market is not likely, however, under H.R. 2698, because of the restrictive income and asset eligibility requirements. Relatively few workers in these income ranges have access to employer-based coverage. In addition, the availability of a partial subsidy for employer-based coverage could offset some of the incentives to leave employer-based coverage for those low-income workers participating in such coverage. (However, because the health certificate program provides a greater subsidy for the purchase of health insurance in the individual market then for employer-based coverage, it may still encourage some young, healthy employees to leave employer-based coverage for the individual market.)

As a result, the magnitude of the risks the health certificate bill could pose to the employer-based health insurance system would be limited as compared to the Administration's tax credit proposal. If over time, however, the health certificate income and asset limits were lifted to increase eligibility and in addition, funding were increased substantially, the program could end up weakening employer-based health insurance coverage and encouraging a substantial number of employers to drop their health insurance coverage (or not to offer coverage in the first place).

Question asked during the Subcommittee Hearing: What is your recommendation on how to cover the uninsured?

As I recommended in my testimony, to address the problem of the uninsured without weakening existing coverage, a better approach would be a carefully designed expansion of public programs such as Medicaid and SCHIP. Under the FamilyCare proposal, additional federal funding would be provided to states, at their option, to expand Medicaid and SCHIP to more parents in working families. Research shows that expanding coverage to parents so parents and children can be covered by the same public program produces the additional benefits of an increase in enrollment among eligible-but-uninsured children in these programs and an increase in utilization of necessary health care services by children. Such a proposal would strengthen public programs that have a proven ability to provide affordable, comprehensive health insurance to millions of low- and moderate-income families. It also would be a much more efficient use of $50 billion — substantially more of the uninsured would gain insurance, and far less of the money would "leak" to subsidizing people who already are insured. Also worthy of consideration are proposals involving tax incentives for more small employers to offer health insurance to their workers.

Sincerely,

Robert Greenstein
Executive Director
Center on Budget and Policy Priorities

cc: The Honorable Sherrod Brown
Ranking Minority Member
Subcommittee on Health
House Committee on Energy and Commerce